FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004259

Facility Name: Stephenson Nursing Center

Address: 2945 South Walnut (Number) Freeport (City) 61032 (Zip Code)

County: Stephenson

Telephone Number: 815-235-6173 **Fax #** 815-235-1309

IDPA ID Number: 36-6006654

Date of Initial License for Current Owners: 01/01/71

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	x	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	x	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Penny Smith **Telephone Number:** 815-235-6173

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/00 to 11/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Sherry A. Gravenstein
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Gregory A. Dunham, CPA
(Firm Name & Address) Lindgren, Callihan, Van Osdol & Co.
328 West Stephenson, Freeport, IL 61032
(Telephone) 815-233-1512 Fax # 815-233-1487

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	59,860	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	411	369		780	8
9	SNF/PED					9
10	ICF	40,925	14,397		55,322	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,336	14,766		56,102	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.72%

D. How many bed-hold days during this year were paid by Public Aid?
546 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1961

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 7 and days of care provided _____

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: n/a Fiscal Year: 11/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary		1,302	564,713	566,015	(4,189)	561,826	(1,415)	560,411			1
2	Food Purchase											2
3	Housekeeping	217,055	26,746	1,861	245,662		245,662		245,662			3
4	Laundry	145,644	22,097	3,015	170,756		170,756		170,756			4
5	Heat and Other Utilities			148,071	148,071		148,071		148,071			5
6	Maintenance	71,337	51,624		122,961		122,961		122,961			6
7	Other (specify):* central supply purch	45,380			45,380		45,380		45,380			7
8	**TOTAL General Services**	479,416	101,769	717,660	1,298,845	(4,189)	1,294,656	(1,415)	1,293,241			8
	B. Health Care and Programs											
9	Medical Director			4,400	4,400		4,400		4,400			9
10	Nursing and Medical Records	2,585,796	194,448	247,479	3,027,723	(2,066)	3,025,657		3,025,657			10
10a	Therapy											10a
11	Activities	133,689	2,222		135,911		135,911		135,911			11
12	Social Services	53,440			53,440		53,440		53,440			12
13	Nurse Aide Training			3,238	3,238	2,066	5,304		5,304			13
14	Program Transportation		3,113		3,113		3,113		3,113			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,772,925	199,783	255,117	3,227,825		3,227,825		3,227,825			16
	C. General Administration											
17	Administrative	85,583			85,583		85,583	27,888	113,471			17
18	Directors Fees											18
19	Professional Services			7,253	7,253		7,253		7,253			19
20	Dues, Fees, Subscriptions & Promotions			4,355	4,355		4,355		4,355			20
21	Clerical & General Office Expenses	97,303	14,134	6,132	117,569		117,569		117,569			21
22	Employee Benefits & Payroll Taxes			455,236	455,236	4,189	459,425	424,428	883,853			22
23	Inservice Training & Education			88	88		88		88			23
24	Travel and Seminar			4,056	4,056		4,056		4,056			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							44,235	44,235			26
27	Other (specify):*											27
28	**TOTAL General Administration**	182,886	14,134	477,120	674,140	4,189	678,329	496,551	1,174,880			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,435,227	315,686	1,449,897	5,200,810		5,200,810	495,136	5,695,946			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Stephenson Nursing Center #0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			110,794	110,794		110,794		110,794			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **bequests**			25,270	25,270		25,270		25,270			36
37	**TOTAL Ownership**			136,064	136,064		136,064		136,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			25,100	25,100		25,100		25,100			39
40	Barber and Beauty Shops			625	625		625		625			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			80,506	80,506		80,506		80,506			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			106,231	106,231		106,231		106,231			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,435,227	315,686	1,692,192	5,443,105		5,443,105	495,136	5,938,241			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,415)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,415)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	496,551	VII B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 496,551		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 495,136		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Stephenson Nursing Center

ID# 0004259

Report Period Beginning: 12/1/00

Ending: 11/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,415)	0	0	0	0	0	0	0	0	0	0	(1,415)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,415)	0	0	0	0	0	0	0	0	0	0	(1,415)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	27,888	0	0	0	0	0	0	0	0	0	27,888	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	424,428	0	0	0	0	0	0	0	0	0	424,428	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	44,235	0	0	0	0	0	0	0	0	0	44,235	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	496,551	0	0	0	0	0	0	0	0	0	496,551	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,415)	496,551	0	0	0	0	0	0	0	0	0	495,136	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Stephenson Nursing Center** **#** **0004259** **Report Period Beginning:** **12/1/00** **Ending:** **11/30/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(1,415)**	**496,551**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**495,136**	**45**

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	employee benefits	$	stephenson county, illinois	100.00%	$ 424,428	$ 424,428	1
2	V	26	insurance		stephenson county, illinois	100.00%	44,235	44,235	2
3	V	17	county administrator		stephenson county, illinois	100.00%	11,158	11,158	3
4	V	17	county treasurer		stephenson county, illinois	100.00%	4,109	4,109	4
5	V	17	county clerk		stephenson county, illinois	100.00%	4,753	4,753	5
6	V	17	county board		stephenson county, illinois	100.00%	6,438	6,438	6
7	V	17	county courthouse		stephenson county, illinois	100.00%	1,430	1,430	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 496,551	$ * 496,551	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Stephenson Nursing Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0004259

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,954 B. General Construction Type: Exterior Block & cement Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing facility	392,040	1853	$	1
2					2
3	TOTALS	392,040		$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98			1971	$ 613,691	$ 15,342	40	$ 15,342	$	$ 475,608	4
5	66			1988	1,687,286	42,182	40	42,182		569,459	5
6	alzheimers unit			1993	189,427	4,735	40	4,735		39,069	6
7	garage building			1972	2,912		20			2,912	7
8	building			1984	149,592	3,740	40	3,740		60,716	8
	Improvement Type**										
9	improvements			1980	15,878		10			15,878	9
10	boiler repairs			1981	1,000		15			1,000	10
11	roof repairs			1981	10,634	532	20	532		10,634	11
12	sidewalks			1982	1,276	63	20	63		1,191	12
13	improvements			1983	2,555	103	25	103		1,826	13
14	improvements			1987	3,816	255	15	255		3,588	14
15	improvements			1989	27,483	687	40	687		8,588	15
16	improvements			1992	8,038	804	10	804		7,636	16
17	improvements			1981	1,110		10			1,110	17
18	improvements			1994	8,557	214	10	214		1,515	18
19	improvements			1994	8,991	899	40	899		6,569	19
20	improvements			1995	8,258	207	10	207		1,353	20
21	parking lot expansion			1995	10,659	533	40	533		3,220	21
22	water heater			1996	2,475	247	20	247		1,454	22
23	water heater			1996	3,449	345	10	345		1,969	23
24	fire dampers			1996	744	30	10	30		170	24
25	parking lot expansion			1996	26,914	1,346	25	1,346		6,785	25
26	roof top air/heat units			1997	14,936	1,493	20	1,493		6,721	26
27	smoke detectors			1997	2,248	225	10	225		1,012	27
28	carpeting & vinyl			1997	3,828	383	10	383		1,723	28
29	roof top air/heat units			1998	14,997	1,500	10	1,500		5,249	29
30	water heater/sprinkler system			1998	17,742	1,775	10	1,775		6,210	30
31	carpeting & vinyl			1998	3,449	345	10	345		1,207	31
32	blacktopping			1971	6,755		10			6,755	32
33	roof			1979	11,804		10			11,804	33
34	roof			1978	9,092		10			9,092	34
35	roof			1978	4,546		10			4,546	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	tuckpointing	1975	$ 2,700	$ 77	35	$ 77	$	$ 1,980	37
38	fire doors	1975	4,443	127	35	127		3,247	38
39	plaster	1976	917	26	35	26		659	39
40	alarm system	1976	350	10	35	10		250	40
41	fire alarm	1983	1,360		10			1,360	41
42	alarm system	1990	11,316		10			11,316	42
43	water softener	1990	9,178		10			9,178	43
44	dehumidifier	1990	9,500		10			9,500	44
45	ansul fire door	1999	1,374	138	10	138		344	45
46	roof a/c unit	1999	11,080	1,108	10	1,108		2,770	46
47	paving	2000	7,942	317	25	317		476	47
48	smoke wall	2000	13,973	698	20	698		1,048	48
49	boiler	2001	4,752	238	10	238		238	49
50	steel door	2001	569	7	40	7		7	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,953,596	$ 80,731		$ 80,731	$	$ 1,318,942	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 217,286	$ 22,626	$ 22,626	$	10	$ 142,765	71
72	Current Year Purchases	5,733	287	287		5	287	72
73	Fully Depreciated Assets	435,111					435,111	73
74								74
75	TOTALS	$ 658,130	$ 22,913	$ 22,913	$		$ 578,163	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	resident use only	ford bronco	1990	$ 3,313	$	$	$	5	$ 3,313	76
77	resident use only	colt wagon	1989	9,359				5	9,359	77
78	resident use only	dodge van	1999	35,748	7,150	7,150		5	17,874	78
79										79
80	TOTALS			$ 48,420	$ 7,150	$ 7,150	$		$ 30,546	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,660,146	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 110,794	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 110,794	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,927,651	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,576	$	$ 1,576
2	Books and Supplies			145		145
3	Classroom Wages	(a)	261	1,888		2,149
4	Clinical Wages	(b)		944		944
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			490		490
9	TOTALS		$ 261	$ 5,043	$	$ 5,304
10	SUM OF line 9, col. 1 and 2	(e)	$ 5,304			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 90,198	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	781,032		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	27		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 871,257	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,953,596		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	706,550		16
17	Accumulated Depreciation (book methods)	(1,927,651)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,403		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,738,898	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,610,155	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 95,692	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,437		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	due to other co. funds	288,848		36
37	other payables	81,249		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 702,226	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 702,226	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,907,929	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,610,155	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,823,959	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,823,959	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	92,406	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **adjust for compensated absenses**	(8,436)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 83,970	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,907,929	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,964,695	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,964,695	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	20,797	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 20,797	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	125	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,023	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,148	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,826	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,826	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	real estate taxes	525,098	28
28a	bequests	15,947	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 541,045	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,535,511	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,298,845	31
32	Health Care	3,227,825	32
33	General Administration	674,140	33
	B. Capital Expense		
34	Ownership	136,064	34
	C. Ancillary Expense		
35	Special Cost Centers	25,725	35
36	Provider Participation Fee	80,506	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,443,105	40
41	**Income before Income Taxes (line 30 minus line 40)****	92,406	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 92,406	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,688	2,080	$ 47,650	$ 22.91	1
2	Assistant Director of Nursing	1,848	2,080	47,282	22.73	2
3	Registered Nurses	27,940	31,096	561,909	18.07	3
4	Licensed Practical Nurses	23,971	26,623	414,256	15.56	4
5	Nurse Aides & Orderlies	136,857	147,020	1,398,161	9.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,808	2,080	32,945	15.84	9
10	Activity Assistants	11,036	12,123	100,744	8.31	10
11	Social Service Workers	5,481	6,052	53,440	8.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,723	6,363	71,337	11.21	17
18	Housekeepers	28,881	30,190	217,055	7.19	18
19	Laundry	17,926	19,897	145,644	7.32	19
20	Administrator	1,768	2,080	50,336	24.20	20
21	Assistant Administrator					21
22	Other Administrative	1,744	2,080	35,246	16.95	22
23	Office Manager					23
24	Clerical	9,724	10,765	97,303	9.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,926	2,103	23,854	11.34	31
32	Other Health Care(specify)					32
33	Other(specify) cent sup/dining rm	16,382	17,566	138,065	7.86	33
34	TOTAL (lines 1 - 33)	294,703	320,198	$ 3,435,227 *	$ 10.73	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 621,560		35
36	Medical Director	12	4,800		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	2,400		39
40	Physical Therapy Consultant	560	23,253		40
41	Occupational Therapy Consultant	371	14,652		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	51	2,327		43
44	Activity Consultant	20	880		44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,038	$ 669,872		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,271	$ 43,433	ln 10 col 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	8,844	174,816	ln 10 col 3	52
53	TOTAL (lines 50 - 52)	10,115	$ 218,249		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Gravenstein	Admin	0	$ 50,336
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 50,336

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Freeport Journal Standard	Requests for bids	$ 168
Lindgren, Callihan, Van Osdol	Cost report & audit	2,500
Altschuler, Melvin & Glasser	Medicare cost report	4,585
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 7,253

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,913
Unemployment Compensation Insurance	6,314
FICA Taxes	259,156
Employee Health Insurance	454,784
Employee Meals	4,189
Illinois Municipal Retirement Fund (IMRF)*	106,045
Employee incentive program	452
TOTAL (agree to Schedule V, line 22, col.8)	$ 883,853

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,733
Health Care Worker Background Check	
(Indicate # of checks performed 33)	396
Co. nursing home assoc of il	1,640
INHAA dues	75
Heaton Pub, operations manual	225
Heaton pub, activity policy manual	136
UHF purchasing	150
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,355

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,650
Seminar Expense	
see attached	2,406
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,056

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 **Report Period Beginning:** 12/1/00 **Ending:** 11/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **County Nursing Home Assoc. $1,640**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,505** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **80,506**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,189** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **11,518**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Lindgren, Callihan, Van Osdol & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **County report not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.